To implement an integrated and affordable regionalized health system to deliver basic preventive and curative health services to 70% of the rural population of Haiti.
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APPENDICES
I. BACKGROUND AND SETTING

Haiti is among the least developed countries in the world and is the least developed in the Western Hemisphere. The high incidence and prevalence of communicable disease and malnutrition, the high infant, child and maternal mortality rates, etc., are viewed as major constraints to Haiti's overall social and economic development. While no adequate studies have been made on the effects of ill health on the productivity of Haitian workers in rural areas, it is evident that improved health will be necessary if the pace of rural development is to increase and if health is not to become major obstacle to the increased agricultural productivity which is Haiti's major hope for development as a nation, in addition to being an immediate necessity for feeding the present population.

A. Major Health Problems

Rural Haitians are among the poorest people in one of the world's poorest countries. Their health status reflects their poverty, lack of adequate health knowledge and practices, and the lack of even the most basic health services and other social services in rural Haiti.

Health statistics and vital statistics in Haiti are as inadequate as those found in most poor countries. However, the following estimates indicate the severity of health problems:

- General mortality rate: 15.4
- Infant mortality rate: 138.8
- Young child mortality rate: 0.45

Although available morbidity data is extremely inadequate, it is clear that the usual health problems found in infants and children in underdeveloped areas take a heavy toll in Haiti; these include malnutrition, diarrheal diseases, and the common communicable diseases of childhood.

Malnutrition is common in Haiti; a study in 1958 found that between the ages of one and six nearly one Haitian child in four suffered from moderate to severe (Gomez Scale II or III) malnutrition, and it is believed that malnutrition has increased since then. PAHO has found in its region of study (Les Cayes) that child mortality is 10 to 33 times higher than that found in developed
countries. This is due largely to the association of nutritional deficiency with infectious disease. (40-70% of infant deaths are caused by this association and 63% of all reported deaths in Haiti (1957) were among children under five years of age.)

Various estimates of average daily per capita food intake indicate a caloric intake of 1600 to 1700 calories, with 40-50 grams of protein and about seven grams of animal protein. High carbohydrate intake combined with low protein and inadequate other nutrient intake is common even among rural families which raise vegetables and animals (e.g., chickens), because such vegetable and animal products are often sold in the local markets, where those families in turn purchase other foodstuffs for their own consumption. Seasonal and short-term fluctuations in local market food prices also contribute to inadequate and unbalanced diets.

Enteric infections are highly important problems from both a medical and a public health point of view. Typhoid and paratyphoid are serious problems with typhoid endemic in a number of urban areas. If regional data (Les Cayes) are projected nationwide, 6,000 cases of typhoid may be expected annually. In 1968, there was a water borne typhoid epidemic in Port-au-Prince. Gastroenteritis (bacillary dysentery) also constitutes a serious problem although insufficient data are available to appreciate the size of the problem. Within this category of illness, infant diarrhea constitutes the most serious health hazard. During 1963-64, 47.9 percent of all admissions to the pediatric service of the University Hospital in Port-au-Prince were for gastroenterities as were 40.5 percent of the pediatric deaths in this service. In 1969 54.4 percent of the pediatric discharges from the same hospital were cases of gastroenteritis. The number of cases of gastroenteritis in the interior is difficult to estimate due to lack of statistics.

Strong evidence exists that Haiti has unusually high rates of tuberculosis, neonatal tetanus, malaria, and helminthic diseases.

Tuberculosis is a major public health problem in Haiti and a major killer of persons of all ages. No data is available which will permit any exact statement with regard to the magnitude or characteristics of the tuberculosis problem. WHO and GOH estimates range from 1.8 to 3 percent of the Haitian population with active
tuberculosis. Twenty percent of all children 15 and under are classified as tuberculosis "infected." The tuberculosis problem is particularly serious under conditions where malnutrition is widespread (as many sufferers of malnutrition do not give positive tuberculin reactions).

Tetanus neonatorum is the most important cause of infant mortality in Haiti. Tetanus has a high correlation with poor sanitation and inadequate medical services. Regional data from an area with which an active tetanus program indicates that from 1956-1960, 14% of live births died from tetanus neonatorum (infection of the umbilical stump). If these figures are projected to the rest of the country where little has been done to prevent tetanus, a total of 10,886 tetanus deaths annually may be expected in children under one year.

Malaria continues to be a major health problem despite anti-malaria measures implemented since 1958. Virtual malaria control was achieved in 1968 as indicated by the blood slide positivity rate (SPR) of 0.21% with an excellent coverage of 1,173,905 slides collected. However, from 1970 the incidence of malaria started to increase significantly and in 1975 the total number of positive slides reported was 24,733 giving an SPR of 7.13%.

<table>
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<th>Years</th>
<th>Slides Collected</th>
<th>Positive</th>
<th>SPR</th>
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<tr>
<td>1968</td>
<td>1,173,905</td>
<td>2,562</td>
<td>0.21%</td>
</tr>
<tr>
<td>1975 (Jan-Apr)</td>
<td>136,405</td>
<td>13,934</td>
<td>10.2%</td>
</tr>
<tr>
<td>1975 (Jan-Dec)</td>
<td>346,934</td>
<td>24,733</td>
<td>7.13%</td>
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Nevertheless, since 1973 malaria was no longer spread country-wide, but instead was localized in six well known areas of the country. Currently, anti-malaria measures undertaken by SNEM have not been effective in controlling this disease in these hyper-endemic foci.

A final category of illness which constitutes a major health problem in Haiti, especially in the rural areas, is helminthic disease. Ascariasis (roundworm infection) is prevalent in the rural areas, particularly during the mango season, where the heavy infestation in already malnourished infants and children is a serious problem. Hookworm is widespread and is an important contributing cause of anemia. Data on filariasis is not available, but it is known that there is a certain amount of infection with nocturnal micro-filaria transmitted by Culex fatigans. It is surprising that there is no schistosomiasis reported since vectors are available and the disease occurs in the neighboring Dominican Republic.
B. Causes of Poor Health Status

The causes of the poor health status of rural Haitians, like their disease problems, do not seem to differ markedly from those found in other poor rural nations. Poverty is probably most important: the per capita GDP is less than $100, and the income of the majority of rural families are far below that figure; in the Northwest, for instance, it is estimated that the per capita annual incomes is less than $60. Anthropologists have stated that rural Haitians seem to be more involved in a cash economy than many other rural groups, so that low cash incomes in this case represent a real inability of families to obtain resources needed for health, well-being, and economic productivity.

Environmental sanitation, is also a major contributing factor to disease in the health sector, directly in the prevalence of water-related diseases and indirectly the relationship of the incidence and severity of diarrheal diseases with widespread malnutrition. "In Haiti it is estimated that 12.5 percent of the population has access to piped water of more or less safety. Direct supply is said to be available to 30 percent of the population in Port-au-Prince but this water cannot be considered safe. Potable water is also available to 10.6 percent of the population in 12 towns covering approximately 264,236 persons. In the rural areas where more than 80 percent of the population resides the availability of potable water is virtually non-existent. Only in the capital is there a drainage system (largely dealing with stormwater), but with insufficient capacity even for this purpose. Food inspection is undertaken on a limited scale only in Port-au-Prince and in one or two of the larger towns.

Protection of the Haitian population (both rural and urban) against major communicable, infectious and vector-borne diseases is grossly inadequate, as indicated by the continuing problems with malaria and tetanus. One of the keys to reductions in the problems associated with many of these diseases is increased coverage with basic preventive health services.
C. Constraints in the Public Health Sector

To date the Haitian health services system has been grossly inadequate to serve the overall health needs of Haiti's rural population and, specifically, to address the health problems cited above. Haitian public health institutions, are severely limited in terms of human, physical and budgetary resources, and as a result, lack the necessary capacity to plan and implement effective health service programs. These constraints are outlined below:

1. **Human Resources - Personnel**

   In Haiti there is an overall shortage of personnel in all categories of health workers. The lack of personnel is particularly serious in rural areas. According to WHO, Haiti global manpower pattern compared to the rest of Latin America and the Caribbean is as follows:

<table>
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<th>LA (Per 10,000)</th>
<th>Haiti (Per 10,000)</th>
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<tr>
<td>Physicians</td>
<td>6.9</td>
</tr>
<tr>
<td>Nurses</td>
<td>2.3</td>
</tr>
<tr>
<td>Auxiliaries</td>
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   Interventions to overcome this personnel constraint must seek to: (a) increase their workers; (b) gear their training more to rural health problems; and (c) improve their quality and distribute them geographically.

2. **Institutional Constraints**

   a. The low level of general administrative capability in the present health ministry (MOH) poses a major constraint to the development of the health sector. There is virtually no long-range health planning, and consequently no coherent long-term health plan. Salaries of MOH personnel are so low, that they must seek other employment in addition to their MOH jobs. There is little unified authority for health matters within Haiti.

   The delivery of health services to the rural populations is scattered and dispersed among the MOH, and other agencies (agriculture, the military), private missionary groups, or voluntary agencies, making for a proliferation of separate transportation and logistical support systems. Finally, there are no mechanisms for monitoring and evaluating programs and personnel.
Precise data on medicine and prevalence of diseases is lacking. This lack inhibits rational decision-making for undertakings in the health sector and future remedial actions in the health sector cannot proceed without an adequate system for reporting disease conditions and vital events.

b. Rural health facilities. There are approximately 190 rural dispensaries and a few urban health centers which provide health services to the rural population. Most function by nurses who receive little or no supervision and suffer from a serious lack of drugs and basic material and equipment. Many of the fixed facilities need to be refurbished or rebuilt and more need to be established to reach an often inaccessible population. Such facilities would serve as the referral points for the outreach system of an RHDS.

The fixed facilities also lack any form of support (i.e., transportation, communication and medical supplies); there are few ministry vehicles, no radio communication between health posts, and no unified supply system. Each bureau (nutrition, family planning) vertical organizations (SNEM) or private voluntary organizations, (CARE, HACHO) has its own motor pool procurement and mini-medical supply systems making for an inefficient, duplication of support functions.

As new facilities are refurbished or built by the IDB, they will serve as a point of referral for the population that need continuing care in the two zones affected by the IDB project. (See App. A.)
3. **Severe Budgetary Constraints**

Haiti's current health budget amounts to about $4.5 million. This allocation reflects health investments of about one dollar per capita with the vast majority of the budget divided to salaries (approximately 70 percent) leaving from $1.0 to $1.5 million to pay the operating costs of the total health system (i.e., materials and supplies, drugs, transportation and other operational costs). The operational allocation thus amounts to about $.30 cents per capita.

A large share of this operating budget is allocated to hospitals in the larger urban centers, thus there is a great disparity in the services provided to urban as opposed to rural residents. With such scant financial resources divided to the rural areas, the MOH estimates that 50 percent of the population (this includes all urban and some rural residents) are provided services through the existing fixed facilities and 50 percent of the population (all rural) do not benefit from any MOH services.

Given the present GOH budget for health of $4.5 million and given the fact that approximately 70 percent of the budget is allocated to salaries, it becomes clear that there needs to be a reversal of emphasis from the payment of salaries to the provision of services. The present level of resources for health and the projected increased allocations when taken together, still result in a limited capability in view of the extraordinary need for services; thus the design of the system through which health services are to be delivered is crucial.
D. **Current GOH Responses to Health Problems**

Haiti's health problems, as discussed above, are problems which Haiti shares with other poor countries, although certain problems such as malaria have been more successfully controlled in other countries than in Haiti. These problems are greatest in rural areas and are for the most part susceptible to reduction and control by simple means which can best be applied by (or encouraged within the general population) personnel who must have adequate skills for the relatively simple tasks at hand and who will require ample supervision and support, but whose training need not be complex or highly technical. Broad coverage by adequate basic services is the key to developing health services which will contribute to rural health and national development in Haiti.

At present very few rural Haitians have access to the basic health services which will be required on a very broad scale if significant improvements in rural health status are to be accomplished. Those who do receive such services do so through a few government dispensaries and clinics and, more commonly, through facilities and services sponsored by missionaries and other private groups. It has been estimated that only 50 percent of rural Haitians have reasonable access to any kind of basic modern health services. In the rural areas, most services intended to deal with health problems are provided by indigenous practitioners, whose practices are in many instances prejudicial to the health of the patients. In recent years, the Ministry of Health has shown increasing interest in providing adequate services in rural areas.

Until recently, publicly supported health services in Haiti were limited to high cost, clinically-oriented curative and preventive medicine, primarily geared to the better off urban populations. In August 1971, the MOH initiated an attempt to extend such services to the rural areas through a program of "regionalization," which was to rely on a decentralized network of dispensaries, health centers and regional hospitals. But this approach, although adopted in principle, has not been costed out or adequately developed.

In the past year, the Ministry of Health, under new direction, has shown increasing interest in the possibility of delivering low-cost rural health services through the proposed regional system. In effect, such a system would use the previously favored idea of regionalizing and decentralizing health services, but the content and cost of the health services delivered would be modified to more efficiently and effectively meet health needs. A loan agreement negotiated with the InterAmerican Development Bank will support the renewal and development of rural physical facilities in two parts of the country; these will form part of the new rural
health system in those areas, but due to difficulties of transportation, etc., such facilities are expected to increase the population's access to basic health services to a total of only 30 percent (MOH estimate), leaving more than two-thirds of the population without adequate health care.

The GOH has recently decided to give high priority to development of widespread basic services (in various sectors) in rural areas; the MOH is now considering the various options which it faces in the design and implementation of a rural health system and has requested AID assistance in both planning and implementation. The strategy outlined in the following section describes AID's response to that request, a project to assist the GOH with rural health service delivery system planning and implementation.

Development of a Rural Health Delivery System appropriate to Haiti's needs and culture will be facilitated by making full use of the fund of experience gained by the MOH, missionaries, and other groups which have provided limited rural health services in various parts of the country. In some cases (e.g., MOH, DFH and Nutrition Projects and the Health Services Delivery Project at Petit-Goave Project) a great deal of information has already been compiled and should be readily available for early use. Other projects will require more active study in order to determine their implications for the RHDS.

E. Current Efforts to Deliver Rural Health Services

The GOH and other multilateral and bilateral donors are currently involved in an ad hoc development of rural health delivery services. There are several private, or quasi-private groups currently operating pilot, integrated rural health projects. The HACHO health delivery system and the Division of Family Hygiene (UNFPA, Rockefeller and Bread for the World funding) "agent sanitaire" demonstration project at Petit-Goave, are currently considered as possible models to be replicated for the new rural delivery system. Other models also exist (out-patient services at Albert Schweitzer Hospital and the Mennonite project in GrandeRivière du Nord), but adaptation and replication of any of these models is contingent upon the ability of the MOH to evaluate various projects and to plan and implement all components of a delivery system.
The IDB has accorded a $6.3 million loan to the GOH to construct new and refurbish existing facilities in two of the five sanitary zones. PAHO, independently, and in conjunction with other donors (AID, IDB) is working in the area of developing technical personnel. The MOH (with AID, and UNFPA assistance) through its Bureau of Nutrition and Division of Family Hygiene has also been developing new cadres of health personnel to staff the "redirected" rural health delivery system.

Concerning the availability of safe water, several community-level water projects are conducted in limited areas of the country largely by PVOs (CARE, CRS, HACHO). The IBRD is planning to refurbish 10 urban water systems, and CIDA is planning a water project in the Petit-Goâve area. No nationwide planning or program for environmental sanitation and development of water resources currently exists.

Other individual health problems addressed by AID and other donors include: malaria control (AID, PAHO) and nutrition rehabilitation (AID, PAHO).

F. AID Strategy

At the request of the Government of Haiti (GOH), AID has taken the lead to bolster the administrative capabilities of the MOH to plan, develop, and implement an integrated and affordable regionalized system to promote and deliver basic preventive and curative health services to 70 percent of the rural population of the area. A RHDS depends heavily upon administrative arrangements produced by planning and organization, in addition to competent personnel. AID recognizes that without administration, assessment, planning, organizing management, and evaluation, scarce resources may be diverted to non-critical points in the system.

Detailed design of the rural health delivery system will be carried out under AID grant and loan funding from FY 75 through FY 78, using information and experience gathered by various private voluntary groups in Haiti, currently engaged in rural health delivery.
1. Concept of the Rural Health Delivery System:

The design of any RHDS is very complex, but some basic principles of such systems can be drawn from experience in other areas of the world, on which the Haitian system, as presently conceived, can be built. First, the RHDS must be organized to provide for steady growth in both quantity and quality of medical services. Second, health services must be available close to the patients' homes as possible in the smallest, cheapest staff and equipped unit capable of looking after them adequately. Third, health services must be carefully adapted to the opportunities and limitations of the local culture.

It is anticipated that the RHDS to be developed will fit into the existing Haitian concept of regionalized health service system; that is, a decentralized health system whereby most operational decisions are delegated to each of the five sanitary regions. (See Appendix B for Regional Plan). Each region has a hospital, numerous health centers, and basic level dispensaries. The hospital, numerous health centers, and basic level dispensaries. The hospital is engaged in the more complex medical care while the lower levels in basic health care. The crucial link between this structure and the rural community is the new basic level health worker.

Experience in Haiti and elsewhere indicates that adequate rural population coverage with basic health services will require that Haiti rely upon specially trained basic level health workers, who with adequate support and supervision, will provide preventive, promotive and curative health services at the home and small community level. The aim would be to involve the rural population in the leadership of health programs through the possible use of village health communities and provide health education services and simplified medicine to rural isolated areas.

The basic level worker is thus the key to the rural emphasis of the RHDS. His effectiveness depends on the supervision he receives from trained auxiliaries
Schema of Integrated Health Services

- Basic Health Services
  - Sanitary Post, Sanitary Agent - Rural Areas, Urban Slums
  - Subcenter - Villages
  - Health Center - Urban Neighborhoods, Small Cities
- Basic Hospital Services
  - Community Hospital
- Somewhat Specialized Hospital Services
  - Regional Hospital
- University
- Specialized Hospital Services
  - Regional Specialized Hospital (e.g., Tuberculosis, Psychiatry)
  - National Specialized Hospital (e.g., Leprosy)
and medical professionals as one moves up the operational hierarchy. Special training programs will be developed for supervisors, who will themselves play important roles in the initial and continuing training basic workers. An in-service training program will be established in the RHDS, to provide initially for the reorientation of present workers to the new RHDS, and later for the upgrading of their skills and those of workers who enter the RHDS after it has been established.

The actual professional training of doctors and nurses should be limited to filling in the gaps of the expanded RHDS. A community medicine public health orientation should be built into existing medical training facilities in order to orient professionals toward rural health.

2. Administration and Support of RHDS:

In order to keep the rural health delivery system in operation, it must be supported with fairly low cost administrative and support systems.

Trained administrative personnel will be needed at the central, regional and peripheral levels to plan, administer and operate the RHDS and its support systems. Such personnel can be trained through a combination of participant training, on-the-job training (including experience gained by MOH personnel while working with technical assistance workers), and local, regional and national level courses and workshops.

Smooth functioning and flexibility of the RHDS will depend on relatively rapid communication among the various levels of the system, extending from central MOH offices out to the periphery of the system and back. Communications facilities in rural Haiti are completely inadequate, and it is possible that the RHDS may need to acquire or have ready access to a network of two-way radios if its most pressing communication needs are to be met.

An adequate decision-oriented information system will need to be developed within the RHDS (and the MOH in general) if decisions made at central and intermediate
levels are to be effectively implemented and if information needed by decision-makers is to be available in the forms in which it will be most useful. The limited middle-level management capability of the MOH makes the development of an adequate but relatively uncomplicated basic information system all the more important. Studies of expected decision and information needs and resources in the RHDS will be required before such a system can be designed.

A simple but wholly adequate medical supply system will need to be developed, unifying the existing ad hoc supply system in order to provide basic medicines and supplies to the basic level of operation as well as to all other levels of the operational hierarchy.

Transportation services will be provided for personnel, goods and patients. The scarcity and poor maintenance of roads in all rural areas will require that four-wheel drive or other appropriate vehicles be obtained. Maintenance of MOH vehicles is generally inadequate, but the transportation and maintenance systems of SNEM provide models for planning and implementing such system in the MOH once preliminary studies have established estimates of RHDS transportation needs.

In Haiti, maintenance of government buildings and equipment, especially outside of the capital, ranges from nonexistent to sporadic but completely inadequate. A basic maintenance program, including facilities and trained personnel and emphasizing preventive maintenance, will be established. In addition, maintenance requirements and problems will be simplified by the project's emphasis upon basic services not requiring high levels of technology (and complicated equipment) and by the development of standardized equipment and supply lists. SNEM provides a fund of maintenance experience which will be used in developing the RHDS maintenance system.

3. GOH-AID Strategy to Develop a Rural Health Delivery System:

AID's strategy will be to develop a integrated national rural health delivery system in Haiti with the GOH and other donors. The AID strategy is to provide within
the MOH the context within which an integrated health delivery system can be designed, tested, implemented, evaluated and replicated at a cost affordable by the Haitian economy. Also, effective coordination will be sought between the MOH and other GOH and private entities which impact on health, i.e., rural sanitation, potable water, agriculture, road construction. This will be accomplished in the following manner: 1) to strengthen the administrative support capability of the Ministry of Health in planning, budgeting, implementing, and evaluating a national system at the national, regional and district levels; 2) to train or retrain technical and administrative personnel to operate in the RHDS in coordination with IDB and PAHO; 3) to provide on a national basis the clinical referral system to support the demand created by the RHDS service outreach activities in the three zones not covered by the IDB; and 4) to design a process whereby existing non-governmental activities are integrated into the RHDS. Integrated RHDS is one in which the services provided by the MOH through its several divisions and bureaus reach the target populations in a uniform way to the extent possible within the same physical or human delivery point. That is, maternal child health, family planning nutrition services, etc. are all provided either in the same physical setting (clinic) or by the same multi-disciplined workers. This is in contrast to the existing vertical systems of delivery such as separate maternal child health, family planning, malaria control rural sanitation, nutrition (mother craft center) and the rest of health services, i.e., clinics and dispensaries.

The strategy recognizes the need to develop targets for coverage by the RHDS over a period of years. At this time, it is anticipated that AID will support extension of the RHDS on a national basis. By 1985 it is expected that approximately 60% of the total population will be covered by the national health services delivery system and that malaria will be controlled so that it no longer is a major health problem.

The AID strategy is to assist in planning and implementing malaria control program which, for the first time in Haiti, utilizes a comprehensive approach to malaria control.
utilizing all available methods of vector control, drug
treatment and source reduction. This comprehensive
approach will be aimed at a reduction of the incidence
of malaria to the point where it is no longer a serious
health problem. The reason a comprehensive approach is
recommended is due to mosquito resistance to the DDT
currently used. It is anticipated that the develop­ment
of such an RHDS will be carried out in three
phases:

Phase I:  Strengthening of Health Services I (FY 75 and
FY 76) $682,000. This phase is essentially geared toward
the improvement of the health planning and administration
capability in the Ministry of Health. A U.S. contract
team is to be financed to create a functioning bureau
of national health planning, develop a national health
development plan, assess the data base, manpower,
training, administrative and logistic support require­ments
for a RHDS. Detailed studies of the existing
private systems will be carried out for possible
replication. During this first phase, some of the
reforms of high priority will be initiated.

Phase II: Strengthening of Health Services II (FY 77).
This phase includes a grant of $400,000 and loan of
$5.6 million of loan to develop and implement a five
year plan of operations for the control of malaria
during (1977-81).

Grant funds of $3.0 million and loan funds of $1.4 million
will be used to support full-scale training of Ministry
and periphery level medical technicians, management and
support personnel, and basic level community workers.
In addition, the grant will finance technical assistance
to put into operation: 1) an improved personnel system
through reforms of the present system; 2) an improved
financial system linking the Ministry with the
periphery; 3) an improved information and data
collection system; 4) task assignments within the
RHDS; 5) final designs and plans for RHDS including a
logistics and supply system, a communications network,
and transportation network with the necessary maintenance
provisions (trained personnel), and an improved facility
and equipment maintenance system. It is expected that
AID will coordinate very closely with the Inter-American
Development Bank and the Pan American Health Organization.
FY 77 loan funds ($5.6 million) will be used to implement the five year plan of operations for the malaria control program, utilizing all available control methods.

Phases I and II should include an intensive review and evaluation of the actual costs of the operations of the new rural health delivery system. Recommendation for budgetary and fiscal reforms must be contemplated so that the GOH can eventually absorb the costs of the new expanded health system.

Phase III: Strengthen Health Services III (RHDS Support System) FY 78. Funding for this phase is proposed in this PRP through a loan of $5.0 million and grant of $500,000. The purpose of this loan is to extend an integrated RHDS on a national basis to a majority of the population at an affordable cost. The system will be supported by para-professionals and the planning Bureau of the MOH drawing on the experience of SNEM. It is expected that the trained personnel and final designs for this system will be financed under the FY 77 project. It is expected that strengthening the Ministry's support capabilities will enable the MOH to consolidate the ad hoc system within the Ministry itself and the parallel support systems for the PVO's.

Grant-funding will be used to finance technical assistance to put these support systems into operation and manage them for about two years.

II. PROJECT DESCRIPTION

The overall purpose of both the FY 77 and FY 78 projects, is to implement an integrated and affordable regionized system to deliver basic promotive, preventive and curative health services to 70% of the rural population of Haiti.

The entire design of this project, including technical assistance, training, construction plans, etc., will be funded under the FY 76 and FY 77 AID grants to the Ministry of Health as part of a general technical package to develop the rural health services delivery system. Thus, it is expected that two years of planning and development will have been carried out by the time this loan is ready for disbursement (for 1979).
It is expected that the RHDS will be extended to sanitary zones where facilities and personnel are in place and in adequate numbers and will be progressively extended from zone-to-zone until the whole country is covered.

The primary sites for introduction of RHDS should be selected from those areas where malaria incidence has already been reduced to an acceptable low level as jointly agreed upon by GOH, PAHO and AID.

This low level of malaria control may release workers formerly employed by SNEM for broader rural health delivery services under the asupices of MOH. This would permit integration of SNEM in a reverse fashion from the concept generally proposed which is to integrate SNEM into the MOH at the national level. SNEM activities area by area will be transferred to the MOH Chief of each of the 11 health districts, (the important local level of responsibility for health programs is the health district). When an acceptably low level of malaria incidence, based on joint PAHO/AID/GOH evaluation is accomplished, the support system, i.e., vehicles, supervision, supplies and personnel, would also be transferred to the responsibility of the Chief of the Health District. In theory, therefore, the SNEM transport system becomes the MOH transport system. Such phasing will be reflected in the transportation design which is being developed by the MOH, and which will determine the overall MOH needs for transportation.

Assuming that malaria is reduced to an agreed to level, the SNEM workers would be released from exclusive malaria work as a principal function and should retrain for programs for RHDS.

The implementation process will be derived from the work of the planning group in the period of January - June, 1977. The group will:

a) Define Population to be served: Zones and economic criteria. Criteria will be developed to determine the appropriate phasing for extension of the RHDS based on the Governmental priorities within health, i.e., the population groups at greatest risks,
such as mothers and children, working males depending on the cost benefit/cost efficiency data provided by the Planning Group.

b) Define Services to be Given: Bearing in mind that major components of health services are already being delivered in some regions, i.e., family planning, nutrition and maternal child health, the design of the RHDS would reflect the integration of these activities at the local level. The assumption is that existing MOH activities such as those conducted by the Bureau of Nutrition and the Division of Family Hygiene will be integrated at the outset. Thus, for example, GOH budget proposals and loan/grant proposals in the years 1979-80 should begin to reflect integration of free standing programs into the RHDS. This integrated model will be extended throughout the country on the basis of integration into zones within which malaria was previously controlled. Comprehensive integration of all national health systems, although an alternate objective, is not necessary the immediate objective which is the provision of integrated services at the rural periphery.

c) Define Alternative Systems or Methodology for Providing Defined Services: Such activities should be based on evidence drawn from public and private health experience in Haiti.

d) Perform Task Analysis: Task analysis flows from the decisions affecting the nature of services to be provided, level of services to be provided and population to be covered. From this analysis, decisions governing the types of workers, numbers of each type of workers, supervisory units, transportation, and logistics, needs will flow. This becomes the basis for determining training requirements, level of MOH supervisory back-stopping required, etc.

e) Calculate Needs for RHDS: Needs for manpower, material and supplies, transport storage, communication and training facilities will be defined by the task analysis and alternative analysis.

f) Project Costs of RHDS: Factors in the projection of costs include: 1) Percentage of population determined to be in need of services and the nature of the services
to be extended; preventive versus curative or some mix of the above; 2) level of services to be provided; 3) percentage of population to be served; 4) to what extent the population will contribute to defraying the costs of the program; 5) the level of government contribution. (The assumption is that the Government of Haiti will be responsible for the full funding of the project at the end of five years. Therefore it is critical to raise these cost questions now); and 6) the potential degree to which agricultural and other sectoral efforts may need to be reviewed to minimize health risks.

g) Define Fee for Service System: Once projected costs are calculated, critical decisions as to budget requirements can be made. Three principal sources are contemplated:

1. GOH
2. Population to be served
3. International loans and grants

A general guideline being discussed is the public sector availability of $3.00 per capita per annum or $15 million as a working budget. The current budget is about $4.5 million. The plan assumes the Government will be able to assume the full cost for the malaria control program by 1981. A critical assumption, then, is that malaria will be controlled to the point where it is no longer a major health problem and that the MOH will be able to maintain that level of control.

If the GOH is in a position to spend $6 million for health, even a 10% increase per year or $600,000 would mean a budget of $10 million within five years. This means a projected deficit of $5 million in five years even with a 10% GOH increase per year. The deficit will have to be covered through funds for services and international loans/grants.

There are two options which the GOH and planners are faced with:

1. Design RHDS which can be fully financed from local revenues. Implications here are development of a rudimentary form of RHDS;
2. Design a more sophisticated system which creates predictable deficits which depend on outside funding sources until the growth of the economy (and therefore GNP) will rise sufficiently to provide the local revenue base necessary to support the RHDS.

h. Initiate training:
   a. Trainers
   b. Trainees

i. Select Implementation Sites: Criteria will have been developed for site selection.

a. Project Elements

Estimates for support of the extension of an integrated RHDS may include the following components:

1. Manpower Development and Training:
   a. Development of a Training System $175,000
   b. Trainers/Trainees 75,000
   c. Four Training Sites - @ $50,000 200,000
   d. Equipment 50,000
   TOTAL $500,000

Priority will be given to retraining former malaria workers and training will include malaria control techniques for multipurpose staff.

2. Commodities - $2,000: A minimum pharmaceutical formulary for the nation should be developed by the MOH. Experience shows that a drug list of 60 items can be developed to respond to most national demand for drugs in similar RHDS systems. The GOH would provide these drugs through the RHDS as the system is extended. Concomitantly, a fee-for-service schedule would be developed to serve as a replacement financing source for future drug needs.
3. **Support System - $32,000**: Composed of transportation, storage, logistics, communications and maintenance.

Options for development of MOH Support Systems which will be considered in each District are:

- a. Incorporate SNEM logistics, storage and maintenance system where malaria has been reduced to an acceptable level;
- b. Share System with SNEM;
- c. Establish a new System.

One of the most critical aspects of the strategy is not to dilute the malaria control effort by the premature incorporation of SNEM activities into the RHDS. The grant element of $1.2 million will provide technical assistance and training in support of the Support System.

4. **Other Possible Components**: Results of Planning Group will determine if it should be incorporated into FY 78 PP.

   **Rural Sanitation Program**: Should be tied in with source reduction program of SNEM. Must insure that maintenance of sanitation projects developed in conjunction with source reduction now undertaken by SNEM is budgeted by the Regional Health Districts. This will insure that malaria resurgence does not occur due to lack of maintenance of sanitary projects.

   **Nutrition**: One of the most effective ways to assist in the reduction of TB at the level found in Haiti is to raise the level of nutrition of the population. Possible nutrition interventions will be developed either within the MOH or in conjunction with the Department of Agriculture.

   **Water Supply**: There is a possibility that the MOH working with the Department of Public Works, might develop a program which would reach 60 percent of the population not now covered. The present plan, which envisages IBRD financing, confines itself to major and smaller cities and should reach 40 percent of the population.
### Projected Project Costs

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III. Aid and Other Relevant Experience

For the past 10 to 15 years AID has supported projects in Haiti which provide a fund of experience useful in the design and implementation of a national rural health service delivery system. For the past 15 years AID has supported malaria eradication and control efforts and will continue to do so through FY 1981. SNEM (Service National contre les Endemie Majeures) has vast experience in delivering malaria related and other (TB, Yaws) health services to a large portion of the Haitian rural population. In addition, SNEM's administrative structure has proven to be very adequate in delivering these services. As the incidence of malaria decreases the SNEM structure will be used as a training ground for MOH workers and will eventually be programmatically as well as administratively integrated into the unified rural health services delivery system.

In addition to these essentially health sector activities, AID has and continues to support integrated community development projects under the direction of private voluntary organizations such as CARE, the Haitian American Community Health Organization (HACHO), and the Catholic Relief Services (CRS). These projects, as well as privately funded projects such as health project in Petit-Goave, provide additional valuable experience and tested approaches to the delivery of rural health services within the Haitian context.

In several current and proposed rural health projects, in other AID countries has recognized the need for strengthening the RHDS systems in order to provide health coverage to the majority.
IV. BENEFICIARIES

Primary beneficiaries of the RHDS to be developed under this project will include the poor, rural population served by the health delivery system. The rural population represents approximately 80% of the population of Haiti. While the average population density for Haiti is 156/ Km² (1971) in terms of arable land the average density exceeds 490 Km² (the highest density in Latin America).

Subsistence agriculture (on plots averaging less than 2.5 acres) constitutes the chief economic activity in the rural area. While per capita GDP estimates range from less than $100 to $120 per year, the per capita for the rural Haitian is less than $50 per year. Estimates of the caloric intake of rural Haitians vary from 1633 calories per day to 1728 calories per day - among the lowest consumption rates in the world. A disporportionate number of rural Haitians (especially children one through five) suffer from multiple nutritional deficiencies including protein-caloric malnutrition, seasonal vitamin A deficiency with keratomalacia, ariboflavinosis and goiter. The synergistic effect of malnutrition and other communicable diseases (gastroenteritis, arbovirus, etc.) has been noted previously. The malaria regions are also located in the rural areas.

Few public services of any kind are currently provided in the rural areas. Rural schools (which provide education only through the fourth grade) constitute less than 40% of the total number of primary schools and receive less than 10% of the education appropriation. All secondary schools rural population as isolated as does the education and transportation system. Less than 30% of rural households have access to radios and most broadcasts are in French. (More than 90% of rural Haitians speak only Creole).

The present health delivery system provides services to no more than 30% of the rural population. This disparity in coverage is recognized by the MOH, whose regionalized rural health delivery system - to be designed and partially implemented with AID assistance (FY 77 loan/grant) will expand and improve coverage of this presently underserved population.
The rural health delivery services (FY 77) to be supported and improved under this project (FY 78) will be designed to maximize their acceptance by the rural people of Haiti. Appropriate consideration will be given to the necessity of adapting such services to local beliefs and practices, and full use will be made of both anthropological knowledge and the relevant experience of those who are already providing rural health services in limited rural areas of Haiti. In keeping with the expected emphasis of the rural health delivery system, the support system will be designed to operate efficiently in supporting the peripheral levels of the rural health delivery system and will use levels of technology most appropriate to the needs for reliable peripheral support systems.

OTHER DONOR ASSISTANCE:

The total health (medicine, nursing, public health, nutrition, etc.) assistance of multilateral, bilateral and voluntary agencies constitutes a major material and technical contribution to the operation of the Haitian health system. (Of the fixed facilities 117 are privately sponsored).

Operating under a basic agreement with the GOH, WHO/PAHO has been providing a wide range of technical services, especially in the areas of: a) strengthening health services; b) family health and population, and c) health manpower development. In the general area of strengthening of health services, PAHO currently provided the major technical inputs into the SNEM malaria control program, in the form of co-directorship of the program and technical assistance in engineering, entomology and epidemiology. In collaboration with the OAS and UNICEF, a project in the Les Cayes area to develop integrated public health services has been initiated; that project provides medical, statistical, nursing and administrative technical assistance and vaccines and equipment.

In collaboration with the UNFPA and AID, a project was initiated in 1972 to develop an integrated maternal and child health and family planning program. This project constitutes the framework for the entire national MCH/Family Planning program, including modified roles for all international donors, was further delineated at a donors' meeting in September 1976.
Finally, PAHO is involved in manpower development in the areas of nutrition (the training of nutrition auxiliaries), nursing auxiliary training, and the preparation of veterinary personnel and sanitary engineers.

Another major source of multilateral assistance is the IDB/GOH loan of 1975 for 6 million dollars for the construction and rehabilitation of fixed facilities in two areas of the country. Under this loan PAHO will provide the necessary technical, administrative and financial assistance. This project is considered by the GOH to be a key component in revitalizing and restoring the rural health services delivery system.

A large number of U.S. voluntary agencies, missions, foundations and other non-profit organizations provide material aid and technical assistance in the fields of medicine, public health, education and community development. Several of these programs may constitute rural health delivery models which may be further examined in the development of the national rural health services delivery system.

All foreign assistance is coordinated by the MOH office of "Controle de L'Assistance Exterieure". Improved coordination among the donors would contribute to the overall strengthening of the planning and administrative capability of the central ministry.

VI. ISSUES AND ANALYSIS:

A. Technical Analysis: Integrated Rural Health Delivery System Analysis which will form the basis for designing the RHDS will be carried out during the PP development. It is expected that an interim report will be submitted between October - December 1977 which will provide the analytical basis for the design of a RHDS. The technical analysis will be based on the following: (utilizing demographic and entomological data).

1. Analysis of existing RHDS prototypes
2. Synthesis of national prototype(s). AID is now supporting approximately 21 prototypes globally.
3. Definitions of level of services
4. Preparation of task analysis
5. Projection of costs
6. Definition of private and public mix.

This analysis is required in order to determine the following requirements for extension of an integrated RHDS:

1. Institutional requirements
2. Manpower
3. Implementation Strategy
4. Requirements for support system.

In the absence of such an analysis it is premature to predict what system the results will recommend.

B. Institutional Issues: The executing agent for the proposed loan is the Ministry of Public Health/Population. Institutional issues for the FY 78 RHDS include:

1. SNEM: Implementation of the program in the field will not be adequately insured unless a plan of operation is implemented. Critical factors will be the proper structuring of the plan of operations and insuring, through site evaluation, that the plan of operations is being implemented. Otherwise malaria will not be reduced to a level which will allow integration of SNEM into the MOH.

2. MOH: A critical constraint is the degree to which the GOH can absorb and make appropriate use of the total level of donor support, assuming a national RHDS prototype design is developed and SNEM is integrated into the MOH.

C. Economic Analysis: This project is an integrated rural health delivery system to be developed over fiscal years 1975 through 1977. Some of the salient factors affecting the economic analysis of the system are:

1. A quantitative measure of demand which can serve as a baseline to other needs (i.e., number of
expected births, say 35/1000, number of out-patient visits per person per year). These examples could be used for a comprehensive description of health needs and consequently affect demand on the system.

2. Setting priorities and deciding how much of need can be met by existing resources of the RHDS (i.e., doctors per thousand, auxiliaries, equipment, vehicles, medications, etc.), and community resources such as money, materials, traditional healers, midwives, etc.).

3. The influence of distance in determining the distribution of health care facilities.

4. Cost effectiveness of using non-professional and auxiliary personnel for primary care and to effect health changes in the community to free professionals for planning, consulting, teaching and managing.

5. Cost effectiveness of long-range planning and budgeting in the RHDS - effects of better managerial methods on the system as a whole.

6. Future recurring costs of the RHDS.
D. FINANCIAL ISSUES:

Between December 1974 and December 1975, Haiti's outstanding external public debt increased from DR 46.2 million to DR 70.2 million. About on-half of the debt outstanding at the end of 1975 was in the form of loans received from other governments (the U.S. and Canada), while another two-fifths consisted of loans from international agencies (IDB and IBRD). The average maturity of the public foreign debt is about 24 years, with a grace period of about five years on the average. Given the concessionary character of most loans given to Haiti, the average interest rate on the total public debt outstanding is less than 3.0 percent, while total debt service on the external debt represents less than 0.4 percent of the GDP or about 4.5 percent of the value of exports of goods and services. The debt service ratio to the GDP so far has not unduly burdened the government's financial resources.

The financial resources of the health sector are composed of the 1) budget of the Ministry of Health; 2) funds earmarked to health by other state institutions, e.g., the health services of the Armed Forces of Haiti, and the Ministry of Social Affairs; 3) financing from international organizations such as WHO, AID, UNICEF, UNDP, UNFPA, WFP, etc.; and 4) funds contributed by private voluntary organizations such as CARE, Service Chretien, HACHO, CRS, Research Corporation, OXFAM, and diverse religious sects such as the Catholic church, Baptists, Wesleyans, Episcopalians, Seventh Day Adventists, Mennonites, the Red Cross, etc. A study of the complete financial resources going into the health sector is very necessary, especially if the government contemplates integrating all services into a rural health delivery system and eventually takes charge of the private organizations distributing health care.

The current budget of the Ministry of Health is about $5.0 million, which amounts to a budgetary allocation of about $1.00 per capita for health. This budget is reinforced by outside donor contributions for health development projects. The $5.0 million budget represents about 12% of the amounts to national budget, but much less of the total government revenue. (There are substantial extra-budgetary revenue and expenditures of semi-autonomous agencies such as the Regie du Tabac.) Since the major part of the FY 78 loan is for extension of an expanded rural health system, the present budgetary allocation must be analyzed in order that the GOH can meet recurring costs of the RHDS once donor aid ceases and the GOH takes over the system.
The investment that AID and other donors have undertaken in the health sector will most probably have significant budgetary implications on the GOH when existing concessionary loans grace periods expire and the debt service increases. In addition, the development of a RHDS is expected to be an expansion of health services into rural areas where there is little or no existing health care and will be an increased financial burden to the MOH. The exact magnitude of the RHDS to be developed in the FY 77 project will become clearer in the coming year, and projections of the recurrent budgetary costs of the system can be made for the years when concessionary assistance terminates. These costs are likely to exceed the current budgetary outlays, but in the effort to develop a RHDS within the resources of the GOH, it will be important for the Planning Group to take into consideration that the RHDS System must be affordable. The principal financial issue here is who will finance the recurrent costs of the system which AID and other donors are establishing? As the desired rural health delivery system becomes a reality, so will the costs of maintenance, transportation, communications, personnel, POL, and expendable medical commodities. AID's investment today will require a policy commitment by the GOH for fiscal reforms to support the system once AID support terminates.

Studies Recommended:

1. There are, however, policy alternatives that can be considered which will reduce GOH budgetary expenditures. One alternative is to make the rural population partially pay for the new medical services as they would pay the village healer. Further investigation of this alternative is needed and should require an indepth study of cost of traditional village medicine.

2. An overall study projecting debt burden and overall recurrent costs of all donor projects and its effect on the GOH budgetary process in the next five to ten years should be made.
VII. **FY 78 Project Development Schedule**

**November 1976**

Initiation of Ministry of Health planning effort, including personnel and manpower needs, finances, data information, logistics, communications and transportation requirements for RHDS. This analyses will serve as basis for both FY 77 and FY 78 projects (Phases II and III).

**May 1977**

PP for FY 77 completed which will include provisions for a prototype RHDS to be implemented which will serve as basis for replication in the FY 78 project.

**September 1977**

Detailed interim report on findings of analytical efforts of MOH, status and implementation of the FY 77 grant provisions which affect the FY 78 project. Interim Report will be the basis for DAEC decision to go forward with the design of FY 78 PP.

**February 1978**

Initial trials on prototype RHDS.

**July 1978**

Initial evaluation of trial RHDS and prospects for replicability of RHDS. Design of RHDS program design completed to serve as analytical base for FY 78 PP.

**August 1978**

PP for FY 78 completed.
APPENDICES

A. IDB Loan Construction and Rehabilitation
B. Ministry of Health Regionalization Plan
C. Organization Of the Ministry of Health
D. Current Rural Health Delivery System Development Strategy
E. Initial Environmental Exam
F. Draft Logical Framework for FY 77 and FY 78 RHDS Project
LOCALIDADES EN QUE SE CONSTRUIRAN LOS DISPENSARIOS, CENTROS DE SALUD CON Y SIN CAMAS

REGION NORTE

Localidad Dispensarios

1. Camp Coq        Reemplazo
2. Sainte Suzanne
3. Carice
4. Fignon
5. Ranquite
6. Bahon
7. La Victoire
8. Port Margot
9. Boyeaux        Creación
10. Acul Samedi    Reemplazo
11. Perches
12. Ferrier

Centros de Salud

1. Donjon        Reemplazo

Centros de Salud con 12 camas

1. Trou du Nord    Reemplazo
2. Saint Raphael
3. Borgue
4. Port Liberté
5. Mont Organisé
6. Mombin Crochu

REGION SUR

Localidades Dispensarios

1. Laurent        Creación
2. Mersand
3. Arniquet       Reemplazo
4. Beraud         Creación
5. Changieux
6. Bonbon
7. Beaumont
8. Cayemites
9. La Cahouane
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**Centro de Salud con 20 camas**

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**Centro de Salud con 50 camas**

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**Centro de Salud y Adiestramiento**

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PLAN DE REGIONALISATION

I.- Concept

La loi de Août 1971 a créé de fait un système régionalisé des services de santé du DSFP. De plus la Politique de santé de la présente administration du Département accorde la priorité au développement de la régionalisation sanitaire comme le meilleur mécanisme pour assurer les bénéfices de la santé à la plus grande partie des habitants.

Ce système régionalisé des services de santé se définit comme un ensemble d'éléments ordonnés en unités organico-fonctionnelles dnommées "régions sanitaires susceptibles d'assurer l'usage métodique des ressources humaines et matérielles des institutions de santé publiques et privées. Ces unités sont organisées de manière à pouvoir offrir des services de santé intégraux de quantité suffisante et de qualité adéquate et assurer une meilleure couverture sanitaire de la population à un coût compatible avec les fonds disponibles. Le système se caractérise par la centralisation de l'autorité légale, normative, à l'échelle nationale au niveau de la Direction Générale et la décentralisation administrative et exécutive par le jeu de délégation d'autorité aux administrations régionales.

Établis pour répondre à une demande effective ou potentielle, les services de santé doivent être accessibles au triple point de vue physique, culturel et économique de sorte que la population puisse les utiliser régulièrement (sans barrière géographique, climatologique, légale, culturelle ou financière. Dans cet esprit, l'incapacité de payer d'une grande partie de la population devra être prise en sérieuse considération, les bénéfices de la santé devant être disponibles à tous.

Dans le système, seront périodiquement évaluées l'utilisation et la productivité des services de santé pour se rendre compte du rendement des ressources disponibles.

La Politique de santé du Département répond à tous ces facteurs. Fondamentalement ses décisions se réfèrent à l'extension de la couverture sanitaire de la population, à l'exécution des programmes prioritaires et au développement de l'infrastructure. Le développement de l'infrastructure implique l'organisation régionalisée du système, l'exécution d'une réforme administrative qui permettra d'ajuster l'appareil administratif aux buts de la Politique de santé et l'augmentation et l'entretien de la capacité physique installée. La formation et l'entraînement du personnel nécessaire ainsi que le financement du plan de santé en général sont également indispensables au développement de l'infrastructure sanitaire.

L'une des aspirations les plus fortes de la communauté est de pouvoir disposer de services de santé pour tous ses membres sans exception. Malheureusement, cet idéal de la couverture universelle se voit limité par l'insuffisance de ressources humaines, matérielles et financières.
Pour cette raison, le système régionalisé qui est envisagé espère arriver à des objectifs précis au niveau des établissements sanitaires. Il considère la réalisation des programmes qui ont le plus d'impact sur l'état de santé de la population, il augmente la couverture à travers un système qui offre des services minimum à la plus grande partie de la popu-
lation tout en concentrant les ressources spécialisées à certains ni-
veaux. Ainsi, les établissements de santé sont de complexité décrois-sen-
te du centre à la périphérie. Un système de double référence permettra aux habitants vivant dans la juridiction d'un établissement élémentaire de bénéficier de tous les services disponibles dans la Région. De plus, sera recherchée une complète coordination avec les centres du formation et d'entraînement du personnel sanitaire dans le cadre d'un schéma de régionalisation de l'enseignement.

Les bases fondamentales de la régionalisation sanitaire sont:

-1. C'est un système pyramidal avec une large base située à la périphérie (zones rurales) et le sommet à la capitale. Dans ce grand système pyramidal national, il existe 6 sous-systèmes, pyramidaux, eux aussi, avec une jurisdiction propre qui se définit géographiquement et démographiquement. Ces sous-systèmes sont dénommés "Régions Sanitaires", lesquelles couvrent toutes les aires du pays. Chaque Région Sanitaire coïncide, à quelques exceptions près, à l'un des cinq départements de la division politico-administrative. Seule la 6ème Région Sanitaire qui, vu sa structure différente, sera considérée comme une sous-région, embrasse uniquement l'Aire Métropolitaine (FAP- Pétionville et Carrefour).

À leur tour, les Régions sanitaires se subdivisent en système plus petits, mais toujours pyramidaux et avec une juridiction géographique propre, dénommés "Districts sanitaires". Dans les districts sanitaires existent des systèmes pyramidaux encore plus petits dénomnés "aires ou unités sanitaires".

-2. Le système comprend de nombreux niveaux de prestations de services (niveaux de soins) lesquels sont élémentaires à la base de la pyramide et se font plus complexes et plus spécialisés à mesure que l'on monte dans les différents niveaux d'établissements jusqu'au sommet où l'on rencontre l'établissement le plus complexe: l'Hôpital Régional.

Chaque niveau de soins a ses programmes et ses activités nettement définis. De même la quantité et la qualité du personnel ainsi que l'équipement et le bâtiment sont standardisés.

-3. Dans ce système pyramidai de prestation de services, existe aussi une structure administrative qui reconnaît les mêmes instances précédemment énumérées. Basiquement on peut signaler à niveaux:
-a) Niveau Central, représenté par la Direction Générale de la Santé, responsable de l'administration de l'ensemble du système national, situé au sommet de la Pyramide.

-b) Niveau intermédiaire, représenté par les bureaux régionaux qui assurent l'administration des services de leur juridiction.

-c) Niveau local, représenté par l'ensemble des établissements de santé de tous types, ce niveau est producteur de services.

-4. Le système régional est complètement intégré. Il y existe une relation étroite et une coordination entre un niveau de soins donné et les niveaux inférieurs et supérieurs immédiats.

A chaque niveau opérationnel, on devra épuiser toutes les possibilités de soins qui peuvent être donnés localement avant de s'adresser au niveau supérieur suivant. À son tour la Région Sanitaire devra s'organiser pour pouvoir répondre à presque toutes les demandes de soins de sa juridiction. Seulement exceptionnellement elle aura à recourir à l'Hôpital de l'Université d'État qui servira d'Hôpital de référence.

Le système de référence des patients se fera d'après les modalités suivantes: l'envoi des patients d'un niveau inférieur à un niveau où il y a plus de ressources pour compléter un diagnostic ou réaliser un traitement, le retour de ces patients au niveau original avec une indication claire du diagnostic, au traitement réalisé et des soins qui devront être poursuivis par ce niveau. De même une référence d'un niveau supérieur à un niveau inférieur pourra se faire pour raison d'économie et de facteurs personnels du patient.

-5. Il doit exister une "centralisation normative" et une "décentralisation exécutive". La première assure que l'administration des services de santé se réalise suivant des lignes politiques et des normes unifiées et uniformes. La seconde assure une plus grande agilité, la flexibilité et la simplification administrative, en même temps qu'elle doit améliorer l'efficience de la prestation des services.

L'utilisation la meilleure du personnel de santé impose la notion d'une délégation d'attribution du personnel professionnel au personnel technique et auxiliaire pour assurer des tâches spéciﬁques sur la base d'une définition claire de ce qui est délégué, d'un entraînement préalable et d'une supervision efficace. Cela permettra d'augmenter la couverture des services de santé sans pour autant diminuer leur qualité.

Chaque niveau est responsable de la supervision du niveau immédiatement inférieur. Il y contrôlera en outre la qualité et la quantité des services donnés à la population.

Les niveaux supérieurs devront contrôler périodiquement tous les niveaux inférieurs médiat ou immédiats.
6. La régionalisation évite le double-emploi des efforts et des ressources, les lacunes programmatiques, les dépenses injustifiées en matériel technique et services de coût élevé.

7. Le système permettra le plein développement des aptitudes du personnel qui y travaille, grâce à une supervision constructive et à grand contenu d'assistance technique et à des activités éducatives continues adaptées aux problèmes de santé et aux intérêts du personnel.

8. Dans la solution des problèmes de santé, on recherchera toujours la participation de la communauté. La motivation de la population grâce à une meilleure connaissance des problèmes qui l'affecte doit permettre au secteur santé de participer activement dans l'amélioration des conditions socio-économiques générales de la région.

9. Le système favorisera la collaboration entre les établissements de santé publics et privés ainsi que l'homogénéité quantitative et qualitative des services de santé.

10. Compte tenu des ressources financières budgétaires, des ressources matérielles et humaines disponibles et de l'appui de la Communauté, la Régionalisation devra se développer en accord avec les normes nationales pour satisfaire les besoins de santé de la population, harmoniser les politiques et programmes des autres secteurs avec ceux du secteur santé et collaborer de façon positive dans le développement global de la Communauté.

11. Le fonctionnement d'un tel système requiert des communications adéquates entre les différents niveaux. Probablement la situation la plus critique se rencontrera entre les niveaux régionaux, districtaux et locaux.

Les lignes de communication devront être respectées autant que possible afin d'éviter des frictions inutiles. Quand le niveau central s'adresse à la Région ou à l'une de ses composantes et vice-versa quand les éléments constitutifs de la Région communiquent avec la structure administrative supérieure, le passage par les autorités correspondantes sera toujours considéré.

12. Les projets de budget élaborés au niveau régional avec la participation des organismes internes de la Région devront être discutés au niveau central par l'Administration de la Région. Une fois approuvés, le budget régional devra être exécuté moyennant la remise de tranches périodiques et proportionnelles de fonds, à l'exception des parties qui doivent être gardées au niveau central pour services et achats réalisés à ce niveau. L'administration régionale doit recevoir mensuellement du niveau central un état de compte budgétaire qui lui permettra le contrôle comptable.
13. Le personnel technique et administratif de la Région, nommé par le niveau central, dépendra de l'Administration régionale à laquelle il appartendra.

Chaque niveau administratif et chacun des établissements de santé auront un catalogue de postes fixes et permanents. On pourra transférer les personnes, mais pas les postes ni leur équivalent budgétaire.

Par délégation d'autorité, l'Administration régionale, dans sa juridiction, pourra transférer des membres du personnel, prendre des mesures disciplinaires et proposer des promotions, dans le cadre des lois et réglements en vigueur.

14. L'éducation en cours de service du personnel sera organisée et régulièrement pratiquée. L'opportunité d'étude de spécialisation dans le pays et à l'étranger sera offerte au personnel qualifié et méritant travaillant parfaitement sur le terrain.

La régionalisation offre une base excellente pour coordonner les efforts du système de santé avec les institutions d'enseignement. Un travail coordonné entre les éducateurs et les administrateurs de santé est d'importance fondamentale. Les bénéfices s'étendent tant aux institutions d'enseignement qui développeront de meilleurs critères pour élaborer leurs programmes en accord avec les besoins de santé de la population qu'aux établissements de santé qui pourront par ailleurs, améliorer la qualité de leurs services et renouveler constamment leurs structures.

L'éducation continue visera trois buts:

- **Formation** - Dans des aspects spécifiques que nécessite le personnel pour son travail ordinaire.

- **Actualisation** - Pour maintenir le personnel informé des progrès technologiques et des changements au niveau des programmes.

- **Progrès** - Pour permettre au personnel d'approfondir ses connaissances dans les différents domaines des sciences de la santé.

15. Une politique de stimulation du personnel pour le retenir dans ses postes de travail sera installée. Les salaires et autres stimulants en espèce tels par exemple la disponibilité de logement pourront atteindre des niveaux tels qu'ils servent à retenir le personnel dans son poste.

Le travail en équipe, la réalisation d'un travail bien fait dans des établissements bien équipés, dans le cadre de la structure régionalisée, seront des stimulants complémentaires pour le personnel.
16. Les approvisionnements se feront du niveau central vers le Bureau Régional et de là vers les niveaux inférieurs suivant un plan précis et un horaire bien établi.

Les achats se feront au niveau central en fonction des demandes émanées de l'ensemble des régions et dans le cadre du catalogue d'articles de base, strictement nécessaires par la réalisation des programmes prioritaires.

17. Un nombre variable de constructions, de réaménagement et d'équipement d'établissements de santé devra être réalisé pour assurer le fonctionnement normal des régions. Ces ouvrages seront programmés en accord avec une chronologie de développement des Régions sanitaires.

18. Le système d'information statistique sera perfectionné pour que toutes les informations statistiques nécessaires tant techniques qu'administratives soient analysées au niveau régional avant d'être transmises au niveau central. Cela permettra l'évaluation permanente des activités des programmes ainsi que le contrôle administratif requis pour une bonne gestion et une programmation réaliste.

19. Dans le système décrit, une place sera faite à l'investigation du phénomène santé et à l'investigation administrative afin d'explorer constamment de nouvelles méthodes d'action. Ce travail sera aussi utilisé comme moyen d'éducation continue du personnel en service.

20. Les Régions sanitaires seront pourvues de moyens de transport adéquat pour accomplir leur mission. La décision de l'assignation des véhicules tiendra compte des nécessités des services et de la population ainsi que des voies de communication et de la localisation des établissement de santé.
II. Organisation du Système régionalisé du Département de la Santé Publique et Population

NIVEAUX ADMINISTRATIFS:

L'organisation du système des services de santé DSPP reconnait trois niveaux administratifs basiques: Central, Intermédiaire et Local.

a) Niveau Central

La Direction Générale de la Santé Publique a les fonctions suivantes:

- Formulation, exécution et évaluation des décisions de politique et du plan national de santé, en accord avec les politiques et plan de développement économique et social du pays.

- Coordination du plan de santé avec ceux des autres secteurs gouvernementaux et des agences non gouvernementales du secteur santé.

- Élaboration et contrôle de l'application des lois, réglements, normes et procédures sanitaires.

- Administration de son propre système régionalisé des services de santé.

- Gestion des fonds attribués au DSPP dans le budget national.

- Étude et proposition de nouvelles sources de financement pour renforcer le budget général du DSPP.

- Administration du programme de formation et d'entraînement du personnel de santé par des cours nationaux et internationaux au moyen de bourses d'études.

- Participation dans les programmes d'enseignement médical et paramédical.

b) Niveau Intermédiaire

L'Administration de la Région Sanitaire a les attributions suivantes:

- Représentation de la Direction Générale dans les limites de la Région.

- Participation à la planification des programmes de la Région.

- Exécution et évaluation des programmes de santé de la Région.
- Organisation, contrôle et évaluation du fonctionnement des établissements de santé de la Région.
- Coordination des activités médico-sanitaires généralement quelconques tant du secteur privé que du secteur public.
- Supervision des programmes et établissements de santé de la Région.
- Application et adaptation des normes, règlements et procédures émanées du niveau central.
- Formation et entraînement du personnel de santé affecté à la Région par le niveau central.
- Préparation du budget annuel pour le financement des programmes de la Région.

L'Administration du District sanitaire a les attributions suivantes:
- Exécution des programmes de santé de base à travers les établissements de santé de sa zone d'action.
- Prestation des services d'appui ou complémentaires en accord avec son niveau opérationnel.

Supervision et contrôle des programmes et des établissements de santé.

o) Niveau local

Ce niveau est représenté par l'ensemble des établissements qui fournissent directement des services à la population et qui exécutent les programmes sanitaires. Dans ce sens, sont compris dans ce niveau tous les établissements de santé: hôpitaux, Centres de santé, dispensaires quels que soient leur propriétaire, leur importance et leur complexité.

Ces établissements de santé sont disposés suivant une structure horizontale de complexité décroissante du centre à la périphérie pour une meilleure exécution de leurs fonctions à chaque niveau opérationnel, de sorte que la plus grande partie des activités sanitaires se réalise localement.

Il faut noter que cette structure horizontale du réseau des établissements de santé est différente de la structure administrative que nous appellerons "structure verticale".

Dans le système pyramidal national du Département de la Santé Publique et de la population, existent donc deux types de structure: l'une administrative "verticale" et l'autre opérationnelle "horizontale". Ces deux structures bien qu'ayant des inter-relations intimes, sont différentes et ne sont pas superposées, en ce sens qu'elles ont des fonctions spécifiques et comptent des organismes propres et différents pour les accomplir. Ainsi, la Direction générale de la Santé Publique
Les fonctions du niveau local sont:

1.- Prestation des services sanitaires de base à la population de sa zone d'influence.

2.- Prestation des services d'appui ou complémentaires aux établissements de moindre complexité de son aire juridictionnelle.

**DEFINITIONS - 'FONCTIONNEMENT'-**

**Région Sanitaire**

C'est un sous-système régional du système national du DSPP. Elle constitue une entité fonctionnelle avec une direction unique pour administrer les programmes de santé destinés à satisfaire les besoins de la population qui en dépend (population qui varie entre 700,000 habitants et 1,000,000) et appliquer les normes et directives établies par la Direction Générale de la Santé Publique.

La Région sanitaire est dirigée par le Bureau Régional composé d'un Médecin-chef ou Directeur régional et d'un personnel indépendant de l'Hôpital régional (pour la composition complète du Bureau, voir Annexe).

District Sanitaire

C'est un sous-système régional de la Région sanitaire. Il est bien défini géographiquement et administrativement. Il comprend un hôpital de district, des centres de santé et des dispensaires.

Une Région peut compter deux districts ou davantage.

Hôpital Régional

C'est une Institution chargée d'assurer à la collectivité de la région sanitaire intégrée l'assistance médico-sanitaire la plus complète qu'il possible tant du point de vue curatif que préventif et dont les services externes s'étendront jusque dans le milieu familial.

L'Hôpital Régional servira aussi de Centre d'Entraînement et de Formation du personnel médico-sanitaire et d'investigations biosociales.

Enfin l'Hôpital Régional servira comme hôpital de référence pour les cas rencontrés au niveau des Établissements de Santé de moindre importance de la région sanitaire.

L'Hôpital Régional sera donc l'établissement de santé le plus complexe de la région sanitaire. Il comportera:

a) Les Départements de Base suivants
   - Médecine Interne
   - Chirurgie
   - Obstétrique et Gynécologie
   - Pédiatrie

b) Des Services Auxiliaires
   - Laboratoire
   - Pharmacie
   - Radiologie
   - Odontologie
   - Statistiques

b) Cuisine et Diététique
   - Morgue
   - Banque de Sang
   - Histopathologie

c) Des Services Administratifs
   - Administration et Comptabilité
   - Buanderie
   - Transport et Ambulance, etc...
d) **D'autres Services Techniques Complémentaires**

- Urologie
- Orthopédie
- ORL
- Dermatologie

Les dimensions de l'Hôpital Régional seront calculées en fonction de l'aire directe d'influence de cet hôpital et de l'importance de la Région sanitaire en question. Le nombre de lits variera entre 200 et 300.

L'Hôpital Régional est dirigé par un médecin-Chef ou Directeur Médical.

Du point de vue administratif, le Directeur Médical est assisté d'un Chef de Bureau.

Au point de vue technique, le Directeur Médical est assisté d'un Conseil Consultatif composé des différents Chefs de Départements Techniques de l'Hôpital et du Chef de Bureau de l'Hôpital.

Du point de vue normatif, le Directeur Médical relève du Directeur Régional.


Il collabore avec le Directeur Régional à la formation et à l'entraînement du personnel de santé de la Région. Il supervise les activités sanitaires des Établissements de Santé situés dans l'aire directe d'influence de son hôpital. Il collabore avec le Directeur Régional à la préparation du budget annuel des Établissements de son aire d'influence.
Hôpital de District

C'est une Institution de moindre importance que l'Hôpital Régional est chargé d'assurer à la collectivité du district considéré l'assistance médico-sanitaire nécessaire tant du point de vue curatif que préventif et dont les services externes s'étendront jusque dans le milieu familial.

L'Hôpital de District servira aussi de Centre d'entraînement et de Formation du personnel médico-sanitaire du district en coordination avec l'Hôpital Régional sous la supervision du Bureau Régional.

L'Hôpital de District servira comme hôpital de référence pour les cas rencontrés au niveau des établissements de moindre importance dans le district considéré.

L'Hôpital de District comprendra au moins les Services suivants:

a) les Départements de Base
   - Médecine Interne
   - Chirurgie
   - Obstétrique et Gynécologie
   - Pédiatrie

b) Les Services Auxiliaires suivants:
   - Laboratoire
   - Radiologie
   - Pharmacie
   - Odontologie
   - Statistiques

c) Des Services Administratifs
   - Administration et Comptabilité
   - Buanderie
   - Transport et Ambulances ...

Les dimensions de l'Hôpital de District seront calculées en fonction de l'aire directe de cet hôpital et de l'importance du District Sanitaire en question. Le nombre de lits variera entre 100 et 200.

Il est dirigé par un Directeur Médical assisté d'un Conseil Consultatif.

Le Directeur de l'Hôpital de District est responsable de l'administration et de la bonne marche de son Institution ainsi que de l'organisation et de l'exécution des Programmes de Santé dans la zone d'influence de l'Institution dont il a la charge. Il collabore avec le Directeur Régional.
dans l'élaboration du budget de son hôpital, assure le maintien du l'ordre et de la discipline au niveau de cette institution.

Il adresse mensuellement au Directeur Régional un rapport sur les différentes activités de son District Sanitaire.

**Centre de Santé**

C'est un Établissement de complexité intermédiaire destiné principalement aux soins ambulatoires. Toutefois suivant l'importance de la localité où il est placé et son degré d'éloignement d'un centre hospitalier, il peut comporter un certain nombre de lits d'hospitalisation. On a alors un Centre de Santé-Hôpital ou Centre de Santé avec lits. Les autres seront des Centres de Santé sans lits.

Le Centre de Santé avec ou sans lit sera sous la dépendance directe d'un hôpital de District ou d'un hôpital Régional; il devra exercer au niveau de la population qui lui correspond des activités tant préventives que curatives. Il sera dirigé le plus souvent par un Médecin-Résident qui sera responsable de sa bonne marche vis-à-vis du Directeur de l'hôpital dont il dépend et auquel il adressera mensuellement un rapport de ses activités.

La dimension et la complexité du Centre de Santé, le nombre de lits, le nombre de bureaux de consultations et l'existence de certains services auxiliaires de diagnostic et de traitement seront en fonction de sa localisation dans l'aire de la région sanitaire et de la population de sa zone d'influence.

**Dispensaire**

Le Dispensaire est la plus petite unité stable de santé où l'on dispense des soins médicaux; il est à la charge d'une ou de plusieurs auxiliaires. Le Dispensaire réalise sous la supervision directe d'un Centre de Santé ou d'un hôpital les programmes de base simplifiés ainsi que certaines urgences simples à la population intéressée.
III.- Description des Régions Sanitaires

Au point de vue sanitaire la République d’Haiti est divisée en une Zone Métropolitaine (comportant la capitale et ses environs) et cinq (5) régions qui sont:

Région NORD .......... I
Région NORD-OUEST ....... II
Région CENTRE ........ III
Région OUEST .......... IV
Région SUD ............. V

La Zone Métropolitaine comprend:

1- La Ville de Port-au-Prince
2- Martissant
3- Carrefour
4- Pétion-Ville
5- La Gonave
6- Fermathe
7- Lilavois
8- Kenscoff
9- Carrefour Georges
10- Furcy
11- Cité Simone Duvalier
12- Croix des Missions
13- Bauaeet
14- Claire Heureuse

La Région I ou Région NORD

La Région Nord est formée des Départements du Nord et du Nord-Est et comprend les Arrondissements, les Communes et les Sections Rurales qui ont font partie. Ce sont:

**CAP-HAITIEN**
Quartier-Norin
Milot
Plaine du Nord
Acul du Nord
Limonade

**TROU DU NORD**
Ste Suzanne
Terrier Rouge
Phadon
Pouletto
Grand Bassin
Caraoul

**ODE RIVIÈRE DU NORD**
Dondon
St-Raphael
Ranquitte
Pignon
Bahon
La Victoire – La Jeune

**PLAISANCE**
Pilate

**LIMBE**
Camp-Coq
Bas-Limbé
Région I (suite)

BORGNE

Port Margot
Petit Bourg Port Margot
Fauché

VALLIRES

Membin crochu
Carice
Laurence

FORT LIBERTE

Dérac
Acul Samedi
Juanaminthe
Capatillo
Perches
Mont-Organisé
Ferrier

La Région II ou Région du NORD'OUEST

Cette région est formée du Département du Nord-Ouest, et d'une part, de celui de l'Artibonite.

Elle comprend les Arrondissements, communes et Sections Rurales suivants:

PORT-DE-PAIX

St. Louis du Nord
La Tortue
Anse à Foleur
Bassin Bleu
La Pointe
Bonneau
Croix St. Joseph
Chansolme

COMAIVIS

Gros-Mornes
Emnery
Terre-Neuve
Anse-Rouge
Sodren

MARETTLADE

St. Michel de l'Attalcye
Bayonnais
Pont de l'Estère
### Région III ou Région du CENTRE

Elle est formée d'une partie du Département de l'Artibonite et du Département du Centre.

Elle comprend les arrondissements, Communes et Section Rurales suivants:

<table>
<thead>
<tr>
<th>HINCHÉ</th>
<th>ST. MARC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maissado</td>
<td>Verettes</td>
</tr>
<tr>
<td>Thomonde</td>
<td>La Chapelle (Deschapelles)</td>
</tr>
<tr>
<td>Thomassique</td>
<td>Desdunes</td>
</tr>
<tr>
<td>Carvajal</td>
<td>Desclines</td>
</tr>
<tr>
<td>Cerca La Source</td>
<td>Grande Saline</td>
</tr>
<tr>
<td>Nmc Joie</td>
<td>Pont Sondé</td>
</tr>
<tr>
<td>Los Pales</td>
<td>Petite Rivière Artibonite</td>
</tr>
<tr>
<td></td>
<td>Mont Rouis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NIKE-BALAISS</th>
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</thead>
<tbody>
<tr>
<td>Savanette</td>
<td></td>
</tr>
<tr>
<td>Saint d'eau (Ville-Bonheur)</td>
<td></td>
</tr>
<tr>
<td>Lascahobas</td>
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<tr>
<td>Belladère</td>
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</tr>
</tbody>
</table>

### Région IV ou Région OUEST

Elle est comprise les départements de l'Ouest en dehors de la Zone métropolitaine et le Département du Sud-Est.

<table>
<thead>
<tr>
<th>JACMEL</th>
<th>LEOGANE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cayes-Jacmel</td>
<td>Grang Goave- Grossier</td>
</tr>
<tr>
<td>Bainet</td>
<td>Petit Goave</td>
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<tr>
<td>Marigot</td>
<td>Viallet</td>
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<td>Lafond</td>
<td>Beaudin</td>
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<tr>
<td>Marbial</td>
<td>Los Palmes</td>
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<tr>
<td>Cap Rouge</td>
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<tr>
<td>La Vallée</td>
<td>Saintard</td>
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<tr>
<td>Mapou</td>
<td>Thiotte</td>
</tr>
<tr>
<td>Trouin</td>
<td>Arcatais</td>
</tr>
<tr>
<td>Ternier</td>
<td>Savane Zombi</td>
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<td></td>
<td>Duvalierville</td>
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<td></td>
<td>Oriani</td>
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<td>Thomazeau</td>
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<td></td>
<td>Chauffard</td>
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<td></td>
<td>Cornillon</td>
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<td></td>
<td>Nazareth</td>
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<td></td>
<td>Croix des Bouquets</td>
</tr>
<tr>
<td></td>
<td>Ganthier</td>
</tr>
<tr>
<td></td>
<td>Marché à lier</td>
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<tr>
<td></td>
<td>Fond Parisien</td>
</tr>
<tr>
<td></td>
<td>Fond Vurettes</td>
</tr>
<tr>
<td></td>
<td>Bodari</td>
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<table>
<thead>
<tr>
<th>BELLE-ANOUDA</th>
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</thead>
<tbody>
<tr>
<td>Grand-Gosier</td>
<td></td>
</tr>
<tr>
<td>Anse à Pitre</td>
<td></td>
</tr>
<tr>
<td>Banane</td>
<td></td>
</tr>
<tr>
<td>Grande Rivière</td>
<td></td>
</tr>
</tbody>
</table>
**De Région V ou Région SUD**

Elle est formée des arrondissements du Sud et de la Grande-Anse. Elle comprend les arrondissement, les communes et les sections rurales suivants:

**CAYÉS**
- Torbeck
- Port-Salut
- St-Jean du Sud
- Camp-Perrin
- Chantal
- Arniquet
- Île à Vaches
- Charpentier
- Méniche
- Mâzennod
- Laborde
- Ducis

**TIBURON**
- Anse d'Hailnault
- Irois
- Dame Marie
- Chambellan
- Cahouane

**JERBAIE-OU GOU-ANSE**
- Corail
- Pastel
- Roseaux
- Abricots
- Moron
- Bonbon
- Cabecu
- D'espagne
- Marfranq - Marché Léon

**ANSE-À-VIQUA-(IPPES)**
- Miragoane
- Petit Trou de Nippes
- Petit Rivière de Nippes
- Barbères
- L'Asile
- Paillant
- Delate
ORGANIGRAMME DU DÉPARTEMENT DE LA SANTÉ PUBLIQUE ET DE LA POPULATION

CURRENTLY
SPONSORED
TRAINING OF
VILLAGE LEVEL
Auxiliaries

DIRECTOR GENERAL

SERVICES ADMINISTRATIFS

AFFAIRES JURIDIQUES

SÉCRÉTARIAT

AFFAIRES INTERNATIONALES

CORRESPONDANCE

ARCHIVES

SERVICES TECHNIQUES

STATISTIQUES

PLANIFICATION EVAUATION

SERVICES SPÉCIAUX

DIRECTION GÉNÉRALE

ENSEIG MEDICAL ET PARA-MEDICAL

POPULATION

ENSEIG NATIONALS SPÉCIAUX

ÔNTRÔLE DE L'ASSISTANT EXTERIEUR

SERVICES ADMINISTRATIFS

DIVISION D'ADMINISTRATION

COMPTABILITÉ

FINANCES PUBLIQUES

TRANSPORT

PERSONNEL

ACHATS ET APPROVISIONNEMENT

MATERIEL

SALARIÉS

INVENTAIRES ET MENS.

SERVICES TECHNIQUES

DIVISION D'ONCOLOGIE

DIVISION D' obsess publique

DIVISION DE RECHERCHE HUM.

DIVISION D'HOG FAMILIALE

ADMIN.

ETUDE

CONTROLE

NURSING

APPENDICE C

ADMIN DISPOSITIFS sanitaires

DIV DE VIH

DIST DE PETEOSE

DIST DE FAMILLE
APPENDIX:

RURAL HEALTH SERVICES DELIVERY SYSTEM: DEVELOP, IMPLEMENT, EVALUATE:

Jan. - Dec. '78

System Implementation
(a) Implement system in Sites Previously Determined
(b) Recalculate Initial Costs
(c) Recalculate Projected Costs
(d) Develop Evaluation Systems
   1. Services Delivery
   2. Training
   3. Logistics

Jan. - Dec. '79

1. Assess Evaluation Reports
2. Continue Implementation
3. Monitor Demand
4. Calculate Replacement Costs
5. Establish Local Budgets to Finance Costs
6. Explore New Starts
   (a) Potable water
   (b) Sanitation
   (c) Agricultural/Nutritional
APPENDIX:

RURAL HEALTH SERVICES DELIVERY SYSTEM: DEVELOP, IMPLEMENT, EVALUATE:

Jan. - June '77

System Definition
Conference on RHSDS:
(a) Analyze Existing Types
(b) Define National System
(c) Analyze Fee-For-Service Schemes, Private & Public
(d) Define Data Needs
   1. Demographic
   2. Epidemiological

WHO

COH

USaidaD Contractor
International Consultants
USaidaDPHA

STRATEGY:

July - Dec. '77

System Development
(c) Define Population to be served
(b) Define Service to be given
(c) Do Task Analysis
(d) Calculate Needs
   1. Manpower
   2. Material & Supplies
   3. Transport
   4. Storage
   5. Communication
   6. Training Facilities

(e) Project Costs
(f) Define Fee-For-Service System
(g) Initiate Training
   1. Trainers
   2. Trainees

(h) Select Implementation Sites
INITIAL ENVIRONMENTAL EXAMINATION

Project Location: Haiti
Project Title: Haiti Rural Health Delivery System II
Funding: FY 78 $5,000 million
Life of Project: Five Years
IEE Prepared by: LA/DR

October 7, 1976

Environmental Action recommended:
A negative environmental determination is recommended.

Concurrence:

Scott Behouteguy, Mission Director

Donor Lion, AA/LA

Approved

Disapproved
Description of the Project:

The project proposed in this PRP is part of a general health sector program to create a prototype integrated rural health delivery system in a given geographical area in Haiti, test it, then replicate the system throughout Haiti. As currently conceived the RHDS will make available to the rural population both curative and preventive health services through least expensive means, i.e., use of the basic level health worker supervised by trained health personnel and supported by an administrative network affordable to the Government of Haiti.

Elements of the project include: 1) strengthening the central ministry's planning and administrative capability to run a RHDS, 2) training and retraining of health personnel, 3) refurbishment of outreach facilities, 4) commodities (drugs and expendable medical supplies) 5) an adequate transportation communications, and medical supply support system. Other possible elements that could be included in the RHDS but which will need more careful investigation will be water supply, rural sanitation and nutrition.

The prototype RHDS will probably be set up in
an area where the incidence of malaria is at a low level. The accomplishment of low level of malaria control may release workers from SNEM (the Haitian malaria eradication agency) for broader rural health delivery services under the auspices of the MOH. Malaria control through the use of pesticides drainage, or source reduction will thus be a minimal although important part of the RHDS activities.

If rural sanitation and potable water elements are attached to the activities of the integrated rural health delivery system, then the effect would be to improve rather than pollute the environment.

**Identification and Evaluation of Environmental Impacts:**

See attached.

**Discussion of Impacts:**

Impacts cited under water quality, air, and health all relate to the possible use of pesticides, control of malaria. The malaria control is expected to be integrated into the RN in areas where malaria is at an acceptably low level as jointly agreed upon by GOH, PAHO and AID.
<table>
<thead>
<tr>
<th>GOALS</th>
<th>INDICATORS</th>
<th>MEANS OF VERIFICATION</th>
<th>ASSUMPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve the quality of life in rural Haiti and to diminish health sector constraints to national socioeconomic development.</td>
<td>-Diminished rural-urban migration</td>
<td>-Economic analyses and demographic studies</td>
<td>-Poor health is a major constraint to development in Haiti.</td>
</tr>
<tr>
<td></td>
<td>-Increased agricultural output per worker</td>
<td></td>
<td>-Either constraints acting in concert with health will also diminish, or health improvement alone will release constraining effect.</td>
</tr>
<tr>
<td></td>
<td>-Increased GDP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBGOAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To improve the health status of the rural people of Haiti</td>
<td>-Decreased morbidity</td>
<td>-Record and vital statistics reviews</td>
<td>-Non-health system factors will not outweigh the effects of health system improvements and thereby prevent the attainment of better health.</td>
</tr>
<tr>
<td></td>
<td>-Decreased mortality</td>
<td>-Epidemiological studies</td>
<td></td>
</tr>
<tr>
<td>PROJECT PURPOSES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To implement in (geographically defined areas of Haiti) an integrated and affordable regionalized system to deliver basic promotive, preventive and curative health services to 75% of the rural population of the areas.</td>
<td>-Coverage</td>
<td>-RHDS record reviews</td>
<td>-Adequate functioning of logistics and support system developed under FY78 project.</td>
</tr>
<tr>
<td></td>
<td>-Quality of care</td>
<td>-Special studies</td>
<td>-Timely completion of IDB construction project.</td>
</tr>
<tr>
<td></td>
<td>-Community acceptance</td>
<td>-Community surveys</td>
<td>-Contract health planning work (RPR 921) is carried out and MOH develops (and GCM adopts) a five year health plan including RHDS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Observations of RHDS operations</td>
<td>-RHDS personnel continue to function in their intended roles.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Decreased malaria prevalence in selected areas (to _ per 1,000)</td>
<td>-Prevalence surveys</td>
<td>-SNEM carries out activities in their five year operations plan in a timely fashion.</td>
</tr>
<tr>
<td></td>
<td>-Decreased vector counts in selected areas</td>
<td>-Entomological studies</td>
<td>-SNEM trains RHDS workers as needed and turns malaria control operations over to RHDS in selected areas.</td>
</tr>
<tr>
<td></td>
<td>-Maintenance of control after transfer of responsibilities to RHDS workers in selected areas</td>
<td>-Prevalence surveys &amp; entomological studies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Direct observation and record review</td>
<td></td>
</tr>
<tr>
<td>Outputs (for RHDS; SNEM to be added)</td>
<td>1) Adequate candidates or personnel with sufficient skills employed in MOH.</td>
<td>1) Participant trainees return to Haiti and are appropriately employed within RHDS</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2) A functioning training system to provide initial and continuing training to RHDS personnel</td>
<td>2) Required personnel to be trained in Haiti are being trained in system and achieve needed skills by end of training.</td>
<td>2) Review of training documents &amp; records, including terminal competency testing.</td>
<td></td>
</tr>
<tr>
<td>3) Basic documents for RHDS development:</td>
<td>3) Existence of adequate documents</td>
<td>3) Review of documents and field observations to validate them</td>
<td></td>
</tr>
<tr>
<td>- improved personnel system design (including salary adjustments)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- improved financial system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- improved information system</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- task assignments</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- initial plans recommendations for logistic system improvement</td>
<td></td>
<td></td>
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<tr>
<td>- communications network plans</td>
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<tr>
<td>- transportation network plans</td>
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<tr>
<td>- facility, vehicle and equipment maintenance plans</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Inputs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commodities</td>
<td></td>
</tr>
<tr>
<td>Construction (?)</td>
<td></td>
</tr>
<tr>
<td>Participant Training</td>
<td></td>
</tr>
<tr>
<td>Technical Assistance</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX F

### Draft Logical Framework

#### GOALS

To improve the quality of life in rural Haiti and to diminish health sector constraints to national socioeconomic development.

**To improve the health status of the rural people of Haiti**

**PROJECT PURPOSES**

To implement in (geographically defined areas of Haiti) an integrated and affordable regionalized system to deliver basic promotive, preventive and curative health services to 70% of the rural population of the areas.

To carry out malaria control activities nationwide which will reduce the prevalence and transmission of malaria sufficiently to allow adequate malaria control activities to be accomplished (in selected project areas) by non-SNEM MOH workers in the rural health services delivery system.

#### INDICATORS

<table>
<thead>
<tr>
<th>GOAL</th>
<th>INDICATOR</th>
<th>MEANS OF VERIFICATION</th>
<th>ASSUMPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diminished rural-urban migration</td>
<td>- Increased agricultural output per worker</td>
<td>- Economic analyses and demographic studies</td>
<td>Poor health is a major constraint to development in Haiti.</td>
</tr>
<tr>
<td>- Increased GDP</td>
<td></td>
<td></td>
<td>Either constraints acting in concert with health will also diminish, or health improvement alone will release constraining effect.</td>
</tr>
</tbody>
</table>

#### INDICATORS

- Decreased morbidity
- Decreased mortality

- Decreased malaria prevalence in selected areas (to ___ per 1,000)
- Decreased vector counts in selected areas
- Maintenance of control after transfer of responsibilities to RHDS workers in selected areas

- Prevalence surveys
- Entomological studies
- Prevalence surveys & entomological studies

### GOALS

#### MEANS OF VERIFICATION

- Record and vital statistics reviews
- Epidemiological studies

- RHDS record reviews
- Special studies
- Community surveys
- Observations of RHDS operations

- Prevalence surveys
- Entomological studies
- Prevalence surveys & entomological studies
- Direct observation and record review

#### ASSUMPTIONS

- Non-health system factors will not outweigh the effects of health system improvements and thereby prevent the attainment of better health.

- Adequate functioning of logistics and support system developed under FY78 project
- Timely completion of IDA construction project
- Contract health planning work (RFP 522) is carried out and MOH develops (and GOB adopts) a five year health plan including RHDS
- RHDS personnel continue to function in their intended roles

- SNEM carries out activities in their five year operations plan in a timely fashion
- SNEM trains RHDS workers as needed and turns malaria control operations over to RHDS in selected areas
<table>
<thead>
<tr>
<th>OUTPUTS (for RHDS:SNEM to be added)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Personnel to plan, administer and operate the RHDS and its support systems (including central, regional and peripheral level personnel)</td>
<td>1) Adequate candidates or personnel with sufficient skills employed in MOH.</td>
<td>1c) Review of personnel and training records</td>
<td>1) Participant trainees return to Haiti and are appropriately employed within RHDS</td>
</tr>
<tr>
<td>2) A functioning training system to provide initial and continuing training to RHDS personnel</td>
<td>2) Required personnel to be trained in Haiti are being trained in system and achieve needed skills by end of training.</td>
<td>2b) Direct Observation</td>
<td>2)</td>
</tr>
<tr>
<td>3) Basic documents for RHDS development:</td>
<td>3) Existence of adequate documents</td>
<td>3) Review of documents and field observations to validate them.</td>
<td>3) Contract health planning team produces documents listed in RFP 521</td>
</tr>
<tr>
<td>- Improved personnel system design (including salary adjustments)</td>
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<tr>
<td>- Improved financial system</td>
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<td>- Facility, vehicle and equipment maintenance plans</td>
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<table>
<thead>
<tr>
<th>INPUTS</th>
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<tbody>
<tr>
<td>Commodities</td>
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<tr>
<td>Construction (?)</td>
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<tr>
<td>Participant Training</td>
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<tr>
<td>Technical Assistance</td>
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</tr>
</tbody>
</table>
### IMPACT IDENTIFICATION AND EVALUATION FORM

#### Impact Areas and Sub-areas 1/

#### A. LAND USE

1. Changing the character of the land through:
   - a. Increasing the population
   - b. Extracting natural resources
   - c. Land clearing
   - d. Changing soil character

2. Altering natural defenses

3. Foreclosing important uses

4. Jeopardizing man or his works

5. Other factors

#### B. WATER QUALITY

1. Physical state of water

2. Chemical and biological states

3. Ecological balance

4. Other factors

---

1/ See Explanatory Notes for this form.

2/ Use the following symbols:

- N - No environmental impact
- L - Little environmental impact
- M - Moderate environmental impact
- H - High environmental impact
- U - Unknown environmental impact

August 1976
<table>
<thead>
<tr>
<th>C. ATMOSPHERIC</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Air additives</td>
<td>L</td>
</tr>
<tr>
<td>2. Air pollution</td>
<td>N</td>
</tr>
<tr>
<td>3. Noise pollution</td>
<td>N</td>
</tr>
<tr>
<td>4. Other factors</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. NATURAL RESOURCES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diversion, altered use of water</td>
<td>N</td>
</tr>
<tr>
<td>2. Irreversible, inefficient commitments</td>
<td>N</td>
</tr>
<tr>
<td>3. Other factors</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. CULTURAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Altering physical symbols</td>
<td>N</td>
</tr>
<tr>
<td>2. Dilution of cultural traditions</td>
<td>N</td>
</tr>
<tr>
<td>3. Other factors</td>
<td>N</td>
</tr>
<tr>
<td>Introduction of modern health services</td>
<td>L</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F. SOCIOECONOMIC</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Changes in economic/employment patterns</td>
<td>N</td>
</tr>
<tr>
<td>2. Changes in population</td>
<td>N</td>
</tr>
<tr>
<td>3. Changes in cultural patterns</td>
<td>L</td>
</tr>
<tr>
<td>4. Other factors</td>
<td></td>
</tr>
</tbody>
</table>
G. HEALTH

1. Changing a natural environment
2. Eliminating an ecosystem element
3. Other factors

H. GENERAL

1. International impacts
2. Controversial impacts
3. Larger program impacts
4. Other factors

I. OTHER POSSIBLE IMPACTS (not listed above)

See attached Discussion of Impacts.